

Client Name: Fake Client

Client ID #: 11111

ADULT
Initial Level of Care Assessment

Staff completing the form: Fake Client Place of interview: Sample Program

Date of assessment: 7.3.18 Referral source (Name & Phone #) Child Welfare Services

PERSONAL INFORMATION

First Name: Fake M.I. S Last Name: Client Age: 21

Social Security Number: 000-00-0000 Birth Date: 07 / 04 / 1995

Phone Number: (619) 000-0000 OK to leave message? YES NO Preferred Language: English

Address: Currently Homeless
Street City State Zip Code

What are the main reasons you are seeking help here today?

"I'm pregnant and using meth. I can't stop on my own. I have a daughter who is 3 and a son who is 2. I tried to go to outpatient tx but I tested positive so my CWS Worker mandated that I go to Residential Tx."

Gender Identity: Male Female Transgender (M to F) Transgender (F to M)
 Questioning/Unsure Other _____ Decline to state

Sexual Orientation: Heterosexual/Straight Lesbian Gay Bisexual
 Questioning/Unsure Other _____ Decline to state

Are you a veteran? YES NO

Are you pregnant? YES NO Due Date: unknown # of Children under 18: 2

Do you have Medi-Cal? YES NO Medi-Cal Card #: 000000F

Do you have Health insurance? YES NO Insurance Company: Insurance Name

Are you on Medically Assisted Treatment (MAT) (i.e., Methadone, Vivitrol, Suboxone)? YES NO

If YES, list the medication: N/A Where do you obtain this? N/A

Have you ever been arrested/charged/convicted/registered for arson? YES NO

Have you ever been arrested/charged/convicted/registered for a sex crime(s)? YES NO

EMERGENCY CONTACT

Name: Nike Adidas Relationship: Fiance Phone #: (619) 555-5555

Name: _____ Relationship: _____ Phone #: _____

ALCOHOL AND/OR OTHER DRUG USE

Primary Drug	# of Days used in past 30 days	Route of Admission	Age at first use	Date Last Used
Methamphetamine	15	smoke	15	6/5/18
Secondary Drug	# of Days used in past 30 days	Route of Admission	Age at first use	Date Last Used
N/A				
Tertiary Drug	# of Days used in past 30 days	Route of Admission	Age at first use	Date Last Used
N/A				

Have you used needles in the past 12 months? YES NO Decline to state/NA If yes, last used: ___/___/___

Date you last used any drugs including alcohol: 6 / 5 / 2018 Number of days in a row you have been using: 15

How long do you think you have had a problem with alcohol and/or other drugs? 5 yrs.

ALCOHOL AND/OR OTHER DRUG TREATMENT HISTORY

Have you received treatment for alcohol and/or other drugs in the past? YES NO

If yes, please give details:

Type of Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Treatment Facility	Dates of Treatment	Treatment Completed (yes or no)
Outpatient	Outpatient Program Name	5.4.18-6.5.18	N
Residential	Residential Program Name	2.1.15-3.5.15	N

ASAM Dimension 1: Acute Intoxication and/or Withdrawal Potential

Do you have a history of serious withdrawal, seizures, or life-threatening symptoms during withdrawal? YES NO

If yes, please describe:

Client reported that when she stops using she is very tired and has body aches.

Are you currently experiencing withdrawal symptoms, such as tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting, etc.? YES NO

If yes, please describe:

No Current Withdrawal symptoms

Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential)				
COUNSELOR: Please Check one of the following levels of severity				
<input checked="" type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Fully functioning, no signs of intoxication or W/D present.	Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self/others. Minimal risk of severe W/D.	Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe W/D.	Severe signs/symptoms of intoxication indicate an imminent danger to self/others. Risk of severe but manageable W/D; or W/D is worsening.	Incapacitated, with severe signs/symptoms. Severe W/D presents danger, such as seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleeding, or fetal death).

ASAM Dimension 2: Biomedical Conditions/Complications
(Include review of Health Questionnaire and TB Questionnaire in your determination below)

Are you currently taking prescription medications for any medical conditions? YES NO If yes, please describe:

I have not seen a doctor for this pregnancy. The last time I went to the doctor was in 2017 when I had my daughter (1st child). The client is concerned that she continues to lose weight and does not have an appetite.

Severity Rating – Dimension 2 (Biomedical Conditions and Complications)				
COUNSELOR: Please Check one of the following levels of severity				
<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input checked="" type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Fully functioning and able to cope with any physical discomfort or pain.	Adequate ability to cope with physical discomfort. Mild to moderate symptoms (such as mild to moderate pain) interfere with daily functioning.	Some difficulty tolerating physical problems. Acute, non-life threatening medical symptoms (such as acute episodes of chronic, distracting pain, or signs of malnutrition or electrolyte imbalance) are present. Serious biomedical problems are neglected.	Poor ability to tolerate and cope with physical problems, and/or general health condition is poor. Serious medical problems neglected during outpatient or IOT services. Severe medical problems (such as severe pain requiring medication, or hard to control Type 1 Diabetes) are present but stable.	The person is incapacitated, with severe medical problems (such as extreme pain, uncontrolled diabetes, GI bleeding, or infection requiring IV antibiotics).

***Note: For residential programs, if the risk rating on ASAM Dimension 2 is greater than "zero" (0), please submit the completed Health Screening Questionnaire along with this form to assist with obtaining initial authorization.**

ASAM Dimension 3: Emotional/Behavioral/Cognitive Conditions/Complications

Review Risk Assessment and Co-Occurring Conditions Screening form for historical information relevant to this dimension. Include as part of your assessment of severity, below.

Do you have any current thoughts of hurting yourself or others? YES NO If yes, please describe:

Client states she feels hopeless and out of control but denies any thoughts of harming self or others.

Are you currently being treated or sought help in the past for a mental health condition? (For example, depression, bipolar disorder, anxiety, PTSD, psychosis, or other mental health condition). YES NO

If yes, please describe:

In 2015 the Client was diagnosed with Schizoaffective DO and prescribed Zyprexa 10 mg. She stopped taking the medication when she was pregnant with her daughter and has not taken them or received any treatment since then.

If yes to the question above, are you currently prescribed medications for the mental health condition(s) you described?

YES NO

If yes, please describe: Zyprexa 10mg

Do you feel like you are unable to care for yourself (hygiene, food, clothing, shelter, etc.)? YES NO

If yes, please describe: I feel hopeless and out of control.

Do you currently have a therapist and/or psychiatrist? YES NO

If yes, provide name/contact information: I have never had therapy and have not seen a psychiatrist since 2015.

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Feeling down, depressed or hopeless
 Not at all Several Days More Than Half the Days Nearly Every Day
- Needed much less sleep than usual and found you didn't really miss it
 Not at all Several Days More Than Half the Days Nearly Every Day
- Feeling nervous, anxious, or on edge
 Not at all Several Days More Than Half the Days Nearly Every Day
- Had nightmares about a frightening, horrible or upsetting event you've experienced
 Not at all Several Days More Than Half the Days Nearly Every Day
- Seen things that other people can't see or don't seem to see
 Not at all Several Days More Than Half the Days Nearly Every Day
- Heard things that other people can't hear or don't seem to hear
 Not at all Several Days More Than Half the Days Nearly Every Day

Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications)

COUNSELOR: Please Check one of the following levels of severity

<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input checked="" type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Good impulse control, coping skills and sub-domains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).	There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with treatment. Relationships are being impaired but not endangered by substance use.	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.	Severe EBC symptomatology, but sufficient control that does not require involuntary confinement. Impulses to harm self/others, but not dangerous in a 24-hr. setting.	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self/others.

ASAM Dimension 4: Readiness to Change

How long do you think you have had a problem with alcohol and/or other drugs?

5 yrs.

Have you tried to stop drinking/using before? If so, what interfered with your success with that goal?

"I have stopped before, but started up again because I like to get high."

Do you intend to reduce or quit drinking/using in the next 2 weeks?

Definitely no Probably no Probably yes Definitely yes

What substance(s) are you willing to stop using?

Meth

What would be helpful for you now in order to change your drinking/using?

"Stay busy, I need to get clean so I can get my kids back and move back in with my fiance "

What is the possibility 12 months from now you will not have a problem with alcohol and/or other drugs?

Definitely not Probably not Probably will Definitely will

How important is it for you to receive treatment for:

Alcohol problems: Not at all Slightly Moderately Considerably Extremely

Drug problems: Not at all Slightly Moderately Considerably Extremely

Severity Rating – Dimension 4 (Readiness to Change)
COUNSELOR: Please Check one of the following levels of severity

<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input checked="" type="checkbox"/> 3: Significant	<input type="checkbox"/> 4: Severe
Engaged in treatment as a proactive, responsible participant. Committed to change.	Ambivalent of the need to change. Willing to explore need for treatment and strategies to reduce or stop substance use. May believe it will not be difficult to change, or does not accept a full recovery treatment plan.	Reluctant to agree to treatment. Able to articulate negative consequences (of substance use and/or mental health problems) but has low commitment to change. Passively involved in treatment (variable follow through, variable attendance)	Minimal awareness of need to change. Only partially able to follow through with treatment recommendations.	Unable to follow through, little or no awareness of problems, knows very little about addiction, sees no connection between substance use/consequences. Not willing to explore change. Unwilling/unable to follow through with treatment recommendations.

ASAM Dimension 5: Relapse, Continued Use, or Continued Problem Potential

What's the longest period of time that you have gone without using alcohol and/or other drugs? 1 mo-2015-in treatm

If you previously stopped using alcohol and/or other drugs, what are the reasons you started using again?

I started using with my fiance. He uses, but is able to work. All my friends use, I like how I feel when I'm high.

"Triggers" are events, feelings, people, places or things that cause someone to justify using again. Are you aware of your triggers to use alcohol and/or other drugs? YES NO

If yes, please list:

When I see my fiance or anyone else use. When I am bored, or want energy

What are some coping tools you have used in the past to avoid using?

"None, I don't have any." Even with prompting she was unable to identify any coping skills.

Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)

Please Check one of the following levels of severity

<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input checked="" type="checkbox"/> 4: Severe
Low or no potential for further substance use problems or has low relapse potential. Good coping skills in place.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition and understanding of substance use relapse issues. Able to self-manage with prompting.	Little recognition and understanding of relapse issues, poor skills to cope with relapse.	Repeated treatment episodes have had little positive effect on functioning. No coping skills for relapse/addiction problems. Substance use/behavior places self/others in imminent danger.

ASAM Dimension 6: Recovery Environment

Are you homeless or at risk? YES NO Living Situation: Fiance kicked me out/Homeless

Are you currently employed? YES NO

Vocational/Educational Achievements (Highest grade level completed, any training or technical education, etc.):
10th Grade

Do you have friends and/or family that are supportive of you seeking treatment for problems related to substance use?

YES NO If yes, describe:

My Fiance does not want me to use, even though he can without as many problems.

Do you have friends and/or family that might interfere with your treatment for problems related to substance use?

YES NO If yes, describe:

Friends and Fiance still currently use and my family doesn't understand or support me.

PO Contact Name & Phone Number: N/A

Pending court date(s)? YES NO If yes, reason(s) and date(s):

I think I have a warrant. Custody Hearing-7.5.18

Are there any transportation, child care, housing or employment issues that could interfere with your treatment for problems related to substance use? YES NO

Severity Rating – Dimension 6 (Recovery Environment)				
<i>COUNSELOR: Please Check one of the following levels of severity</i>				
<input type="checkbox"/> 0: None	<input type="checkbox"/> 1: Mild	<input type="checkbox"/> 2: Moderate	<input type="checkbox"/> 3: Significant	<input checked="" type="checkbox"/> 4: Severe
Supportive environment and/or able to cope in environment.	Passive/disinterested social support, but not too distracted by this situation and still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment and the client has difficulty coping, even with clinical structure.	Environment toxic/hostile to recovery (i.e. many drug-using friends, or drugs are readily available in the home environment, or there are chronic lifestyle problems). Unable to cope with the negative effects of this environment on recovery (i.e. environment may pose a threat to recovery).

Optional Risk Rating Summary	
Dimension	Risk Rating
1 (page 3)	0
2 (page 3)	2
3 (page 4)	3
4 (page 5)	3
5 (page 6)	4
6 (page 7)	4

Level of Care Determination Instructions

After completing the assessment (and determining the risk ratings) in each of the six dimensions, review the "Levels of Care" document which describes the typical risk ratings associated with each level of care and can help guide your level of care recommendation.

Once the recommended level of care is determined, document it in the space below. Also document the level of care to be provided. If there is a discrepancy between the two, document the reason(s) for the discrepancy in the spaces provided.

If the assessment results indicate a level of care different than the one your program provides, complete the "Designated Treatment Provider Name/Location" field with the information from the program you will be linking the client to.

DMC-ODS regulations require that a "Licensed Practitioner of the Healing Arts" (LPHA)* make level of care determinations. In the event an LPHA does not conduct the assessment (and an AOD/SUD Counselor does), the Counselor and LPHA must have a face-to-face review of the information, and the LPHA must co-sign the form, indicating their agreement with the level of care determination.

Recommended Level of Care: Enter the ASAM Level of Care that offers the most appropriate treatment setting given client's current severity and functioning: 3.5

Actual Level of Care: If a level of care other than the recommended is provided, enter the next appropriate level of care: 3.5

Reason for Discrepancy (Clinical Override): Check off the reason for discrepancy between level of care determination and level of care provided, and document the reason(s) why:

- Not Applicable
- Service not available
- Provider judgment
- Client preference
- Transportation
- Accessibility
- Financial
- Preferred to wait
- Language/Cultural Factors
- Environment
- Mental Health
- Physical Health
- Court/Probation Ordered
- Other: _____

Explanation of Discrepancy:

Additional Info: Clit declined to state whether she was using needles, due to open CWS case. If clit continues to use she will be endangering the health of her baby, and she has limited insight into the gravity of her CWS case.

Designated Treatment Provider Name/Location: N/A Client admitted to this facility

SUD Counselor _____
AOD Counselor Name (if applicable)

Sud Counselor
Signature (if applicable)

7-2-18
Date

Provisional Diagnosis

*Residential Programs must provide a provisional diagnosis to obtain authorization.
Outpatient Programs may provide a provisional diagnosis.*

Provisional Diagnosis DSM-5 Diagnostic Label(s): F15.20 Amphetamine Use DO Severe

A face-to-face interaction between the AOD counselor and the LPHA to verify the determination of medical necessity for the client regarding this assessment and related forms occurred on: 7/03/2018 (if applicable)

SUD LPHA _____
LPHA* Name

Sud LPHA
Signature

7-3-18
Date

*Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.